Impact of COVID-19 on Peer Support Specialists in the United States: Findings From a Cross-Sectional Online Survey

Wallis E. Adams, Ph.D., M.P.H., E. Sally Rogers, Sc.D., Jonathan P. Edwards, Ph.D., L.C.S.W., Emily M. Lord, M.P.H., Lauren McKnight, M.A., Martha Barbone, D.V.M.

Objective: Peer support specialists (PSS) are an integral part of the mental health workforce. The purpose of this study was to better understand how the COVID-19 pandemic affected their employment status and day-to-day work.

Methods: A cross-sectional, online survey was conducted (May–June 2020). Recruitment occurred through the National Association of Peer Specialists and additional snowball sampling. Closed- and open-ended questions sought information about employment status, work tasks, challenges faced by PSS and by individuals they supported, and positive impacts they experienced.

Results: A total of 1,280 surveys were analyzed. Nine percent of respondents reported having lost their job as a result of COVID-19. Of these, 65% reported a length of employment of 2 or more years, and 61% reported working 35 hours or less per week. Job tasks changed dramatically, with 73% reporting engagement in new tasks, including increased reliance on technology (N=717), increased coordination of resources (N=123), and COVID-19–related tasks (N=142). Engagement in some support tasks decreased significantly from prepandemic levels, including individual support provision ($p<0.001$) and group facilitation ($p<0.001$). Respondents reported significant challenges among individuals they supported, including increased isolation (92%), substance use (67%), housing instability (38%), and food insecurity (64%). Although respondents also reported challenges, satisfaction with organizational and supervisory support was high. Most respondents (73%) reported positive impacts or benefits from the pandemic.

Conclusions: The changing roles and tasks identified in this study have implications for hiring, training, supervising, and supporting peer staff. The peer workforce demonstrated flexibility and commitment to meeting increasing needs.

Psychiatric Services 2021; 00:1–9; doi: 10.1176/appi.ps.202000915

Peer support specialists (PSS) are a growing part of the mental health services workforce; they are employed in diverse settings and perform a broad range of roles (1). The Substance Abuse and Mental Health Services Administration defines a peer worker as a person "who uses his or her lived experience of recovery from mental illness and/or substance use disorder, plus skills learned in formal training . . . to deliver services in behavioral health settings to promote mind-body recovery and resilience" (2). In 2007, the Centers for Medicare and Medicaid Services deemed peer support an evidence-based practice and an important component of a state's mental health system (3).

Although some PSS work as volunteers, peer support is now an organized paid workforce providing services in a range of service settings. The PSS workforce has grown substantially, from approximately 10,000 certified PSS in 2005 (4) to more than 25,000 in 2016 in the United States alone

HIGHLIGHTS

- A survey of 1,280 U.S. peer support specialists in May and June 2020 indicated that 9% had lost paid and volunteer positions as a result of the pandemic.
- Peer support job tasks changed substantially, with less time spent in traditional peer roles, such as provision of individual support and group facilitation, and more time spent on new tasks related to use of technology, connection of individuals with resources, and COVID-19.
- Peer support specialists reported that the individuals they supported were at heightened risk of isolation, substance use, food and housing insecurity, and interpersonal violence because of the pandemic.
- Peer support specialists worked creatively and innovatively to address the needs of the individuals they supported and largely felt satisfied with assistance they received from their employers.

(5). As of 2020, 47 states and the District of Columbia offer peer specialist certification (6). The Veterans Health Administration currently employs several hundred peer support staff (7), and many mental health service organizations have adopted a recovery model that includes hiring PSS (8). Although much of the available research assessing peer support has methodological shortcomings (9, 10), there is some evidence that PSS improve outcomes for people with mental health issues. Specifically, PSS increase engagement and activation in other mental health services (11, 12), reduce the number of hospitalizations (10, 13, 14), improve self-efficacy (10, 15), and support recovery-related outcomes, such as hope and empowerment (14).

The COVID-19 pandemic has had widespread implications for physical, mental, and economic health and well-being. Nonpharmaceutical interventions, such as quarantine, have led to physical isolation, psychological distress, and misuse of substances (16, 17). Job loss was enormous both in the general workforce and among health care and social service workers specifically (18). Frontline workers have experienced increased workload and trauma, making them susceptible to burnout, depression, and posttraumatic stress disorder (17, 19, 20).

The pandemic also ushered in new, abrupt changes to the provision of mental health care. Mental health providers began to engage in new tasks as the pandemic persisted (21, 22). Telehealth is one such change. A 154% increase in telehealth visits during the last week of March 2020, compared with the same period in 2019 (23), reflects pandemic-related telehealth policy changes and a rapid transition to remote engagement of program participants with use of telephonic and virtual platforms. Accumulating information suggests broad satisfaction with telepsychiatry, higher rates of visit completion, and interest in its continuation postpandemic (24, 25). Additionally, mental health care providers, as a primary point of contact with the health care system for many vulnerable individuals, were rapidly required to learn to identify signs of COVID-related illness and mitigation strategies (26). In light of these and other significant changes brought on by the pandemic, this study aimed to assess its impact on work status, changes to job tasks, and new challenges among PSS based in the United States.

METHODS

The authors formed a partnership with the National Association of Peer Supporters (NAPS) to conduct this cross-sectional, online survey. The Boston University Institutional Review Board approved all research procedures and materials. The researchers and NAPS worked collaboratively to develop the research questions and the methods, including five screening questions to ensure that individuals met inclusion criteria. The final survey contained 49 items as follows: demographic information, 12 items; work history and status, 17 items; changes to work tasks, 11 items; new challenges in work, 1 item; questions about technology, 7 items; and an open-ended comment question. All survey items were designed specifically for this study. We used a combination of item and response types (dichotomous and Likert response scales). We developed the items and procedures for survey implementation following the principles of the total design method (27) as well as participatory research methods (28). Participatory action research (PAR) is a process for engaging key stakeholders that is designed to be empowering for end-users and that enables greater control over circumstances—in this case the delivery of peer support services (28). In keeping with PAR, PSS were involved in every aspect of this study, from conceptualization to interpretation of the data to preparing the manuscript for publication.

We undertook several rounds of item refinement, followed by multiple iterations of pilot testing in Qualtrics. In addition, two colleagues unfamiliar with the study purpose tested the online survey several times to check for clarity and skip logic. If an error was detected, several authors reviewed the survey items again.

Survey Participants

The final version of the online survey was distributed through the NAPS Listserv, composed of approximately 6,000 individuals. NAPS sent four e-mails, first to invite individuals to complete the survey and three subsequent e-mails to prompt nonresponders. E-mail recipients could forward the survey link to colleagues or organizations meeting eligibility criteria, allowing for snowball sampling. Individuals were eligible for the survey if they lived in the United States, were 18 years or older, and had worked or volunteered as a PSS for at least 5 hours a week in February 2020, prior to the U.S. COVID-19 crisis. Because of regional and organizational differences in peer job titles (such as peer coaches, peer advocates, recovery specialists, and recovery coaches), we allowed all peer workers to participate. Inclusion criteria were verified by using the screening questions. Individuals not meeting all inclusion criteria were thanked for their interest and told that they were not eligible to proceed.

Data Collection and Monitoring

Data were collected from May 18 through June 22, 2020. Data collection was monitored closely to ensure that surveys were being accessed and completed without difficulty. A total of 1,772 responses were recorded. We eliminated duplicates (N=85), ineligible responses (i.e., those who did not meet all eligibility criteria; N=223), and those who declined or withdrew (i.e., those who began the survey but did not proceed past consent; N=184). The final sample size for analysis was 1,280.

Data Analysis

Responses were downloaded from Qualtrics into SPSS, version 25.0 (29) for cleaning and analysis. We checked for out-of-range values, valid responses, and difficulties with skip

TABLE 1. Characteristics of 1,280 peer support specialists who completed an online survey[a]

Characteristic	N	%
Gender		
Male	362	29
Female	851	69
Other	23	2
Age		
18–29	84	7
30–49	473	38
50–64	555	45
≥65	119	10
Hispanic or Latinx		
Yes	134	11
No	1,102	89
Race		
White	904	73
Black or African American	171	14
Other	88	7
Multiracial	68	6
Educational attainment		
Less than high school diploma	8	1
High school diploma or GED	104	8
Some college or vocational school	448	36
Associate's degree	193	16
Bachelor's degree	314	25
Graduate or professional degree	170	14
U.S. census region		
Northeast	325	26
Midwest	160	13
South	398	32
West	355	29
Personal annual income in 2019		
<$10,000	57	5
$10,000–$29,999	389	34
$30,000–$49,999	444	38
≥$50,000	170	14
I don't know	48	4
Current public benefits		
Receives one or more public benefits[b]	494	41
Does not receive public benefits	721	59
NAPS membership[c]		
Current member	257	21
Past member	138	11
Never member	826	68
Community where currently or most recently employed		
Large city	599	48
Suburb near a large city	207	17
Small city or town	320	26
Rural area	113	9
Length of time as a peer specialist (years)		
<1	121	10
≥1 but less than 2	166	14
≥2 but less than 5	339	28
≥5 but less than 10	347	29
≥10	243	20
Current or most recent job title		
Peer specialist or peer support specialist	722	59
Peer coach or advocate	72	6
Recovery specialist, recovery support specialist, or recovery coach	123	10
Other	301	25
Type of employing organization		
Peer-run organization	369	31
Non–peer-run mental health or social service agency	522	44
Governmental agency or organization[d]	292	25

[a] Some respondents did not complete all items, and percentages are based on the total number of responses received for each item.
[b] Includes Supplemental Security Income, Social Security Disability Insurance, Medicaid or Medicare, Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program, vocational benefits, Department of Veterans Affairs benefits, and subsidized housing.
[c] National Association of Peer Supporters.
[d] For example, U.S. Department of Veterans Affairs.

logic. To determine differences in before-to-after COVID-19 responses, we examined frequency tables; conducted cross-tabulations, chi-square tests, paired t tests, and repeated-measures analysis of variance. In keeping with our PAR approach, NAPS was involved in advising us about data analysis and in interpretation of the quantitative portion of the survey.

Participants who responded yes to the question "Since the coronavirus began, have you engaged in any new tasks in your peer specialist role?" were asked to describe new work tasks as an open-ended response. Responses were analyzed with content analysis (30) by two authors (WEA, LM). Codes were developed inductively and revised throughout the analytic process. Similar codes were grouped together to form broader categories that emerged from the data. We did not use preidentified codes or categories because of a lack of existing data on the subject. The lead author (WEA) reviewed open-ended responses multiple times to identify initial emerging themes. The two aforementioned authors assigned codes to participant responses, and both reviewed final codes and categorization until reaching consensus.

RESULTS

Most respondents were female (69%) and White (73%), and ages ranged from 18 to 89 (mean=50) (Table 1). More than half had an associate's, bachelor's, graduate, or professional degree. Respondents resided in all 50 states and provided services in large cities, small towns, and suburban and rural areas. Forty-one percent of respondents reported currently receiving public benefits, and 39% earned less than $30,000 in 2019. Respondents were employed in a variety of settings. Among those who responded to the survey item, 66% (N=803) reported working full-time before the pandemic.

TABLE 2. Job loss resulting from the COVID-19 pandemic among 1,280 peer support specialists[a]

	Job loss (N=109, 9%)		No job loss (N=1,171, 92%)	
Variable	N	%	N	%
Length of employment (years)[b]				
<1	15	14	106	9
≥1 but less than 2	23	21	143	12
≥2 but less than 5	32	29	307	26
≥5 but less than 10	20	18	327	28
≥10	19	17	224	19
Held volunteer position in February 2020[c]				
Yes	23	21	86	7
No	84	77	1,018	87
N of paid jobs in February 2020[d]				
0	12	11	52	4
1	55	51	884	76
2	32	29	146	13
≥3	10	9	21	2
Hours worked per week in February 2020[e]				
≤10	22	20	108	9
11–20	23	21	130	11
21–35	22	20	160	14
36–40	31	28	562	48
>40	11	10	138	12

[a] Ns and df values vary slightly because of missing responses on some items. Percentages were calculated with the full-sample Ns (N=109, N=1,171).
[b] χ^2=11.45, df=4, p=.022.
[c] χ^2=22.37, df=1, p<.001.
[d] χ^2=56.78, df=3, p<.001.
[e] χ^2=29.57, df=4, p<.001.

Work Status and Changes to Employment

A total of 109 respondents (9%) reported that they were laid off or lost a job because of COVID-19 (Table 2). Among all respondents, 215 (17%) reported that a peer colleague was similarly affected. Respondents' job loss was unrelated to geographic region, type of community in which they worked, or organizational type (data not shown). Among the 109 respondents who lost a peer position since the beginning of the pandemic, 71 (65%) had been employed in their role for 2 years or longer. We examined demographic characteristics (age, gender, race, ethnicity, and level of education) and found that none was significantly associated with job loss (data not shown). Six percent of respondents who had been employed prepandemic reported having no paid or volunteer PSS position at the time of survey completion in May or June 2020 (Table 3). The shifts we observed in employment situations from prepandemic to the time of survey completion were statistically significant (χ^2=867.40, df=6, p<0.001). Of the 1,209 respondents for whom we had complete data, 1,085 (90%) reported working full- or part-time prepandemic, and 1,048 (87%) reported working at the time they completed the survey. Fewer individuals reported being engaged in any employment situation—whether that was full- or part-time work, volunteering, or working and volunteering—while at the same time, 75 individuals moved to the neither working nor volunteering at the time of survey completion.

The number of PSS reporting an inability to pay their monthly bills increased from 287 (24%) before the pandemic to 385 (33%) at the time of survey completion. Ninety-four respondents (7%) reported losing some or all benefits because of COVID-19, and 171 (13%) reported reduced earnings. Almost two-thirds of respondents (N=742, 65%) reported that the pandemic affected their personal financial situation less than it affected the financial situation of most other people. (These percentages are based on the number of responses to the survey items, which varied.)

Changes to Job Tasks

Respondents reported changes to their job tasks since the COVID-19 pandemic began (Tables 3 and 4). First, they reported decreases in administrative tasks, provision of individual support, training, group facilitation, and systems advocacy. Second, since the coronavirus began, approximately three-quarters (N=761, 73%) of those who continued to work reported engaging in new tasks in five main categories: use of technology, connecting individuals to resources, COVID-19–specific tasks, tasks not typically engaged in by peer staff, and tasks related to provision of support. The most commonly reported new tasks were related to technology, such as providing support remotely, learning new technology, and facilitating online groups. Respondents reported increased resource coordination (e.g., connecting individuals whom they supported to food, housing, and transportation) and tasks related to COVID-19 (e.g., getting personal protective equipment, performing temperature screenings, and conducting training). Tasks not typically engaged in by peer staff that increased included case management and administration, and peer-centered tasks included increased outreach and support of their colleagues. Table 4 provides additional information and sample quotations from the survey.

Finally, among the 1,086 PSS who reported current employment and who answered a question regarding service user changes, some (N=487, 45%) reported that the number of individuals they supported increased during the pandemic, whereas others (N=316, 29%) reported that the number decreased. More than half (N=621, 57%) reported that more individuals were reaching out for support since the pandemic began.

Challenges and Support

We provided a checklist of possible adverse experiences as a result of the pandemic (Table 5). Regarding the individuals they supported, almost all PSS respondents (92%) indicated that they were experiencing increased isolation, and more than half reported that they were facing challenges related to increased symptoms affecting mental health, increased substance use, food shortages, and the possibility of job loss. We also asked PSS whether they themselves were

TABLE 3. Changes in work status and job tasks as a result of the COVID-19 pandemic among peer support specialists[a]

Variable	Pre–COVID-19[b] N	Pre–COVID-19[b] %	At survey completion[c] N	At survey completion[c] %	Test statistic	df	p
Work status					χ^2=867.4	6	<.001
Full- or part-time work	1,085	90	1,048	87			
Volunteer	107	9	76	6			
Worked and volunteered	17	1	10	<1			
Not working or volunteering[d]	—	—	75	6			
Job tasks conducted (M±SD)							
Individual support	4.06±1.12		3.33±1.42		t=15.56	1,070	<.001
Clinical or administrative	3.73±1.20		3.66±1.21		t=2.25	1,051	.024
Group facilitation	3.07±1.45		2.35±1.47		t=16.23	1,044	<.001
System advocacy	2.95±1.36		2.61±1.39		t=10.06	999	<.001
Training	2.99±1.24		2.71±1.31		t=7.63	1,024	<.001

[a] Missing responses on some items; a total of 1,209 individuals reported prepandemic work status and status at the time of survey completion. For job tasks conducted, the sample N was 1,134, because the comparison was possible only for individuals employed or volunteering both pre-COVID-19 and at the time of survey completion. Response scale for job tasks conducted: 5, all of the time; 4, most of the time; 3, some of the time; 2, little of the time; 1, none of the time.

[b] February 2020.

[c] Survey conducted May 18–June 22, 2020.

[d] To be eligible for the survey, respondents had to be working or volunteering in February 2020, before the pandemic.

experiencing additional challenges related to their PSS roles since the pandemic began. Most reported experiencing isolation and communication challenges.

On a Likert scale (1, very satisfied; 5, very unsatisfied), respondents expressed being satisfied with the amount of support they were receiving since the pandemic began, including a high level of satisfaction with their organization (mean±SD rating=2.18±1.27), their supervisor (1.99±1.23), and their coworkers (1.91±1.09). When asked about specific types of support (social-emotional, training-educational, or material), mean responses ranged from 2.19 to 2.32.

Almost three-quarters of the 1,070 respondents who reported being employed at the time of the survey and who answered the question regarding benefits that may have accrued since the pandemic began reported experiencing positive impacts of their role as PSS (N=785, 73%). Benefits reported included less time spent commuting, the ease of working from home, learning new technological skills, and being able to support individuals who had been unable or unwilling to receive services because of transportation challenges or preference.

DISCUSSION

A total of 1,280 U.S.-based PSS qualified for, consented to, and responded to a cross-sectional, online survey conducted in May and June 2020 about the impact of COVID-19 on various aspects of their work. To meet inclusion criteria, respondents had to have been employed or volunteering at least 5 hours per week in February 2020, prior to the pandemic. Approximately 9% of respondents reported that they lost a job or were laid off because of COVID-19. Although this is a substantial proportion, it is far lower than the 15% of U.S. adults reporting COVID-19–related job loss (31). Furthermore, in the early months of the pandemic, most respondents believed that the pandemic affected their personal financial situation less than it affected those of most others.

Our results suggest that the work of PSS changed to adapt to the pandemic, with most respondents engaged in new job tasks, including using technology and connecting the persons they served with community resources. Conversely, respondents reported engaging less frequently in many standard tasks, particularly in terms of providing individual support and facilitating groups. These changing roles and tasks have implications for hiring, training, supervising, and supporting PSS. Importantly, additional technological training and equipment are needed, because PSS have been required to provide not only telehealth and remote group support but also technological support to the individuals they serve. These findings comport with those of an early review of the effect of the pandemic on mental health services, which found that individuals benefited from both the practical and the emotional support offered by peers (32). Creative and proactive deployment of digital and online support facilitated both one-to-one connections and group sessions as well as recreational and social activities (32). Although we can identify no other studies assessing job task changes among PSS as a result of the pandemic, our findings align with recent work showing community health workers engaging in multiple new roles and tasks during recent pandemics, including COVID-19 (33).

Respondents reported that the individuals they supported were experiencing significant additional challenges, ranging from material to symptomatic to social challenges and including substantial isolation, substance use issues, housing instability, food shortages, and interpersonal and family violence. This finding is consistent with those of previous studies related to major concerns among individuals living with mental illness, including during the pandemic (26, 34–36). Most respondents reported that more individuals were reaching out for peer support services since the pandemic began, perhaps adding to the demand for PSS services.

Respondents also reported that they themselves were experiencing pandemic-related challenges, especially isolation and difficulties with communication. Despite these

TABLE 4. Self-reported new tasks resulting from the COVID-19 pandemic among peer support specialists, by main category[a]

Category and task	N	%	Example quote
Technology (N=717, 89%)			
Telehealth (individual)	273	34	I began to provide telehealth or virtual support to customers with no face-to-face contact.
Online groups	152	19	I began providing support over the phone and holding groups on an online platform.
Remote meetings	59	7	I do Zoom meetings instead of meeting supervisors, coworkers, and others in the office.
Working from home	49	6	I am now working completely from home, remotely doing peer support by phone.
Remote training, webinars, or presentations	36	5	I am taking trainer courses for virtual peer support facilitation.
Teaching or support	32	4	Tech support to help people get connected to Skype groups or virtual peer support. Lots of troubleshooting.
Phone line (warm line, crisis line, or support line)	29	4	I have started taking calls for the crisis line a few days during the week.
Learning new technology	28	4	We had no online groups prior to the pandemic. Now everything is online, so it is learning that new job role of using Zoom, Google Forms, etc., for just about everything that we do.
New content or social media	22	3	Social media, raising awareness of our services online (Twitter, Instagram, Facebook); before we had a very limited presence.
Connecting individuals with resources (N=123, 15%)			
Food	47	6	Picking up and delivering groceries from my organization's pantry to some of my clients, as well as to some clients in the enrollment and assessment process.
Housing	14	2	Checking in by phone with housing-challenged clients that our agency supported in hotel rooms while they quarantined after a positive COVID-19 test.
Transport	10	1	Taking peers shopping for groceries, doctor's appointments, and things that their case managers used to do before COVID.
COVID-19 related (N=142, 18%)			
Personal protective equipment	36	5	Using personal protective equipment (PPE), facilitating PPE use for my peers, taking other precautions during "intake," when we welcome a new peer to our program.
Screening or temperature	31	4	I have been conducting COVID-19 screenings and facilitating groups virtually.
Train, support, or provide information	22	3	I have developed peer support trainings for employees regarding COVID-19 protocols, safety, and infection control.
Clean or sanitize	21	3	I sanitize the counseling rooms at my agency.
Stimulus checks	7	1	I assist members with finding household items, PPE, and resources, including setting up a bank account to receive the stimulus checks.
Not typically a peer task (N=109, 14%)			
Administration, scheduling, or front desk	30	4	Things have really slowed down, and I am doing more administrative tasks.

continued

challenges, most respondents reported feeling satisfied with the amount of support their organizations, supervisors, and coworkers were providing, which suggests that agencies were able to adequately support PSS during the first few months of the pandemic.

Notably, almost three-quarters of respondents reported positive impacts resulting from the pandemic, many related to the adoption of technologies that allowed for the provision of remote support. The need to address the use of telehealth and technological advances to provide remote support is garnering more attention. For example, Fortuna and colleagues (37) developed and tested a digital peer support intervention and found it to be a promising way to increase the capacity of PSS to use specific digital technology features in their work.

Guinart and colleagues (24) reported that most mental health care providers surveyed in April and May 2020 expressed positive attitudes toward telepsychiatry and expressed interest in its continuity after the pandemic has resolved. However, it will remain critical for the PSS workforce to address the challenges of technological literacy and lack of access to technology that other mental health care providers report.

Moreno and colleagues (22) argued that the mental health care system must adopt greater inclusion of service users as it adapts to the pandemic and implements long-lasting changes. This inclusion may need to go beyond supporting PSS involvement to focusing attention on larger implementation issues (38). Although the findings are based on PSS self-report, they suggest success

TABLE 4, *continued*

Category and task	N	%	Example quote
Case management or psych technician	24	3	I have assisted CCM and TCM [complex case management and transitional case management] team in completing case management tasks.
Supervisory	5	1	I am training for a supervisory position as well as assisting in training a new hire.
Provision of support (N=131, 16%)			
Outreach	46	6	My team is tasked with outreaching to our membership to see how they are faring during the pandemic.
Increased case loads	22	3	Remote services by telehealth doubled client load; contacts two times per week are required.
Support to colleagues	15	2	I turned my focus to assisting frontline staff more intently in terms of speaking to their stresses and emotions during this time. Since our patients have been quarantined, I have been working with staff to have a platform to discuss what they are going through and offering encouragement and hope.

[a] Only individuals employed or volunteering at the time of survey completion (N=1,134) were asked about new tasks. Of these, 807 indicated engagement in new job tasks. For each category, the percentages are based on the 807 respondents.

within the peer support workforce in adapting to new challenges related to COVID-19—success on which to capitalize.

Several limitations of this study should be noted. First is the representativeness of this sample in terms of the entire peer support workforce. However, given the similarity of the demographic characteristics of this survey's respondents to those of samples in previous studies of PSS (31, 39, 40), we are reasonably confident that our respondents are representative of the larger cadre of specialists.

TABLE 5. Challenges faced during the COVID-19 pandemic by employed peer support specialists and by the individuals they supported[a]

	By peer support specialists		By supported individuals	
Challenge	N	%	N	%
Possibility of job loss	279	28	626	59
Isolation	721	73	964	92
Communication challenges	689	70		
Lack of training	277	28		
Lack of protective equipment	165	17		
Lack of other equipment	115	12		
Increase in symptoms of mental illness			911	86
Increase in substance use issues			706	67
Housing instability			404	38
Food shortages or hunger			669	64

[a] Only individuals employed or volunteering at the time of survey completion (N=1,134) were asked about challenges. Responses were missing for some items, and percentages are based on the total number of responses to each item. Respondents could select multiple responses.

We believe that we have adequately represented PSS of color given that the demographic characteristics of survey respondents appear to be in line with other data that have been captured (39). Although our survey represented views of PSS of color, we were not able to adequately identify or explore the potentially disproportionate impact that the pandemic has had on people from many marginalized and underrepresented groups within the PSS and support-recipient populations. This is critical because the pandemic has been shown to shed light on and exacerbate previously existing health inequalities (22).

As with any survey, we relied to some degree on the accurate interpretation of items and respondents' recollection. The survey was carefully constructed with participation from PSS who are familiar with this workforce by using a participatory research approach. Items were vetted and refined numerous times for clarity. However, the effects of measurement error cannot be discounted, because all items were developed for the purposes of this survey.

In addition to these limitations, our survey was implemented in a short, specific time frame (May and June 2020), leaving open the possibility of a time-cohort effect. Different responses might have been found during a different time frame and with a different group of respondents. Finally, it is possible that PSS without easy access to the Internet may not be represented in these results. However, surveyed PSS suggest that the pandemic forced them to rely more than ever on technology and the Internet for their job tasks, suggesting that a substantial proportion of PSS have access to e-mail and the Internet.

CONCLUSIONS

Results suggest that PSS are filling the needs that individuals served in the mental health system have in their daily lives—needs that have increased or become more visible since the pandemic began. These may include needs that mental health programs and clinical staff considered outside their purview or regular job duties. PSS reported using creative and innovative approaches to addressing the increased isolation and other adverse effects of the pandemic and closure of many programs and services. Similar findings have been reported by other researchers (22, 32). It appears that PSS and their organizations demonstrated the flexibility to

address these unplanned needs and to continue providing critical support services during the pandemic. Implications include the need to know more about how the mental health workforce and PSS are being affected during the pandemic and beyond. The reported unexpected benefits arising from the pandemic should be examined to ensure the continuation of flexible, creative, and responsive mental health services.

AUTHOR AND ARTICLE INFORMATION

Center for Psychiatric Rehabilitation, Boston University, Boston (Adams, Rogers, Lord, McKnight); Department of Veterans Affairs Boston Healthcare System, Boston (Lord); Department of Sociology, California State University, East Bay, Hayward (Adams); National Association of Peer Supporters, Norton, Massachusetts (Edwards, Barbone); Bureau of Alcohol and Drug Use Prevention, Care and Treatment, New York City Department of Health and Mental Hygiene, Long Island City (Edwards). Send correspondence to Dr. Adams (weadams@bu.edu).

The development of this article was supported by grant 90RAREM0001 from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), Department of Health and Human Services (HHS). NIDILRR is a center within the Administration for Community Living (ACL), HHS.

The contents of this article do not necessarily represent the policy of NIDILRR, ACL, or HHS, and endorsement by the federal government should not be assumed.

The authors report no financial relationships with commercial interests.

Received December 17, 2020; revision received March 4, 2021; accepted April 1, 2021; published online June 23, 2021.

REFERENCES

1. Gagne CA, Finch WL, Myrick KJ, et al: Peer workers in the behavioral and integrated health workforce: opportunities and future directions. Am J Prev Med 2018; 54(suppl 3):S258–S266
2. What Are Peer Recovery Support Services? Rockville, MD, Substance Abuse and Mental Health Services Administration, 2009. https://store.samhsa.gov/product/What-Are-Peer-Recovery-Support-Services-/SMA09-4454
3. State Medicaid Director Letter (SMDL #07-011). Baltimore, Centers for Medicare and Medicaid Services, 2007. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd081507a.pdf
4. Goldstrom ID, Campbell J, Rogers JA, et al: National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. Adm Policy Ment Health Ment Health Serv Res 2006; 33:92–103
5. Under the Microscope: Perspectives on Peer Support. Washington, DC, National Association of County Behavioral Health and Developmental Disability Directors, 2016. https://www.nyaprs.org/e-news-bulletins/2016/under-the-microscope-perspectives-on-peer-support
6. Peer Specialists. Brattleboro, VT, Copeland Center for Wellness and Recovery, 2020. https://copelandcenter.com/peer-specialists
7. Chinman M, Oberman RS, Hanusa BH, et al: A cluster randomized trial of adding peer specialists to intensive case management teams in the Veterans Health Administration. J Behav Health Serv Res 2015; 42:109–121
8. Ahmed AO, Hunter KM, Mabe AP, et al: The professional experiences of peer specialists in the Georgia Mental Health Consumer Network. Community Ment Health J 2015; 51:424–436
9. Cabassa LJ, Camacho D, Vélez-Grau CM, et al: Peer-based health interventions for people with serious mental illness: a systematic literature review. J Psychiatr Res 2017; 84:80–89
10. Bellamy C, Schmutte T, Davidson L: An update on the growing evidence base for peer support. Mental Health and Social Inclusion 2017; 21:161–167
11. Craig T, Doherty I, Jamieson-Craig R, et al: The consumer-employee as a member of a mental health assertive outreach team: I. clinical and social outcomes. J Ment Health 2004; 13:59–69
12. Druss BG, Zhao L, von Esenwein SA, et al: The Health and Recovery Peer (HARP) Program: a peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophr Res 2010; 118:264–270
13. Clarke GN, Herinckx HA, Kinney RF, et al: Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: findings from a randomized trial of two ACT programs vs usual care. Ment Health Serv Res 2000; 2:155–164
14. Chinman M, George P, Dougherty RH, et al: Peer support services for individuals with serious mental illnesses: assessing the evidence. Psychiatr Serv 2014; 65:429–441
15. Mahlke CI, Priebe S, Heumann K, et al: Effectiveness of one-to-one peer support for patients with severe mental illness—a randomised controlled trial. Eur Psychiatry 2017; 42:103–110
16. Qiu J, Shen B, Zhao M, et al: A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: implications and policy recommendations. Gen Psychiatr 2020; 33:e100213
17. The intersection of COVID-19 and mental health. Lancet Infect Dis 2020; 20:1217
18. The Employment Situation—April 2020. Washington, DC, US Department of Labor, Bureau of Labor Statistics, 2020. https://www.bls.gov/news.release/archives/empsit_05082020.pdf
19. Lotta G, Coelho V, Brage E: How COVID-19 has affected frontline workers in Brazil: a comparative analysis of nurses and community health workers. J Comp Policy Anal 2020; 23:63–73
20. Luceño-Moreno L, Talavera-Velasco B, García-Albuerne Y, et al: Symptoms of posttraumatic stress, anxiety, depression, levels of resilience and burnout in Spanish health personnel during the COVID-19 pandemic. Int J Environ Res Public Health 2020; 17:5514
21. Kopelovich SL, Monroe-DeVita M, Buck BE, et al: Community mental health care delivery during the COVID-19 pandemic: practical strategies for improving care for people with serious mental illness. Community Ment Health J 2021; 57:405–415
22. Moreno C, Wykes T, Galderisi S, et al: How mental health care should change as a consequence of the COVID-19 pandemic. Lancet Psychiatry 2020; 7:813–824
23. Koonin LM, Hoots B, Tsang CA, et al: Trends in the use of telehealth during the emergence of the COVID-19 pandemic—United States, January–March 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1595–1599
24. Guinart D, Marcy P, Hauser M, et al: Mental health care providers' attitudes toward telepsychiatry: a systemwide, multisite survey during the COVID-19 pandemic. Psychiatr Serv (Epub ahead of print, Feb 17, 2021)
25. Avalone L, Barron, C, King C, et al: Rapid telepsychiatry implementation during COVID-19: increased attendance at the largest health system in the United States. Psychiatr Serv (Epub ahead of print, March 18, 2021)
26. Druss BG: Addressing the COVID-19 pandemic in populations-with serious mental illness. JAMA Psychiatry 2020; 77:891–892
27. Dillman DA, Smyth JD, Christian LM: Internet, Phone, Mail, and Mixed-Mode Surveys: The Tailored Design Method. New York, Wiley, 2014
28. Baum F, MacDougall C, Smith D: Participatory action research. J Epidemiol Community Health 2006; 60:854–857
29 SPSS, Version 25. Armonk, NY, IBM SPSS Statistics, 2020
30. Forman J, Damschroder L: Qualitative content analysis; in Empirical Methods for Bioethics: A Primer. Edited by Jacoby L, Siminoff LA. New York, JAI Press, 2007

31. Parker K, Minkin R, Bennett J: Economic Fallout From COVID-19 Continues to Hit Lower-Income Americans the Hardest. Washington, DC, Pew Research Center, 2020. https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest
32. Sheridan Rains L, Johnson S, Barnett P, et al: Early impacts of the COVID-19 pandemic on mental health care and on people with mental health conditions: framework synthesis of international experiences and responses. Soc Psychiatry Psychiatr Epidemiol 2021; 56:13–24
33. Bhaumik S, Moola S, Tyagi J, et al: Community health workers for pandemic response: a rapid evidence synthesis. BMJ Glob Health 2020; 5:e002769
34. Costa M, Pavlo A, Reis G, et al: COVID-19 concerns among persons with mental illness. Psychiatr Serv 2020; 71:1188–1190
35. Serafini RA, Powell SK, Frere JJ, et al: Psychological distress in the face of a pandemic: an observational study characterizing the impact of COVID-19 on immigrant outpatient mental health. Psychiatry Res 2021; 295:113595
36. Campion J, Javed A, Sartorius N, et al: Addressing the public mental health challenge of COVID-19. Lancet Psychiatry 2020; 7:657–659
37. Fortuna KL, Naslund JA, LaCroix JM, et al: Digital peer support mental health interventions for people with a lived experience of a serious mental illness: systematic review. JMIR Ment Health 2020; 7:e16460
38. Jones N, Byrne L, Carr S: If not now, when? COVID-19, lived experience, and a moment for real change. Lancet Psychiatry 2020; 7:1008–1009
39. Cronise R, Teixeira C, Rogers ES, et al: The peer support workforce: results of a national survey. Psychiatr Rehabil J 2016; 39: 211–221
40. Daniels AS, Ashenden P, Goodale L, et al: National Survey of Compensation Among Peer Support Specialists. Mesa, AZ, College for Behavioral Health Leadership, Jan, 2016. https://papeersupportcoalition.org/wp-content/uploads/2016/01/CPS_Compensation_Report.pdf